EXHIBIT 6

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION
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IN RE NATIONAL PRESCRIPTION OPIATE LITIGATION

Salmons v. Purdue Pharma L.P., et al., MDL No. 1:18-op-45268 — MDL No. 2804

Flanagan v. Purdue Pharma L.P., et al., MDL No. 1:18-op-45405 — Case No. 17-md-2804

Doyle v. Purdue Pharma L.P., et al., MDL No. 1:18-op-46327

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DEPOSITION OF TRICIA E. WRIGHT, M.D.

Taken before Kimberly L. Avery
CSR No. 5074
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In your advocacy for women, you -- well, let's get back to the opioid epidemic. The opioid epidemic, do you -- do you consider that the doctors or the physicians are to blame for this epidemic?

MS. FUJIMOTO: Object. Form.

THE WITNESS: I think there are many, many people to -- we could argue about the use of the term "epidemic," but as I've used it before, there are many factors, and I have talked at length of this. There are many factors that have led to the overprescription of opioids, doctors being educated by a -- different people, the American Pain Society, the JCAHO Hospital -- you know, Press Ganey scores that give hospitals higher ranking and doctors higher ranking if they give pain medication.

So there are many, many factors if you want me to have blame. And then there's also the whole factors of, you know, poverty and the crisis of lack of interconnectedness, as the former Surgeon General would say.

BY MR. BILEK:

Q. Well, first of all, would you agree that one of the causes of the opioid epidemic is that there are too many prescriptions for opioids?

MS. FUJIMOTO: Object. Form.

THE WITNESS: I think there was definitely some incidences of unscrupulous clinics that overprescribed. I think -- and this is one of the things I talk about, is that we needed more education for our physicians to prescribe less, to be able to treat pain better without the use of opioids. It's one of the things I advocate for a lot.

One of the problems with the overprescription of opioids is the insurance coverage. Insurance coverage will cover opioids, but they won't cover physical therapy. They won't cover massage. They won't cover a lot of things that are better treatment for pain. And it's much easier to get an opioid prescription than it is any of these other treatments that work better.

BY MR. BILEK:

Q. You would agree that one -- I mean, first of all, have you done any investigation or studies with linking the fact that the opioid -- increased opioid use is directly linked to the increased number of opioid prescriptions over the last 20 years?

A. I'm sorry, could you repeat that question.

Q. I was asking whether you have done any investigations on whether or not the increase of opioid use in our country is linked to the increase of -- of

opioid prescriptions being written?

A. So you are saying the -- you are asking me if the increase in the amount of opioids used is because of the increase in prescriptions; is that what you are asking?

Q. As one of the reasons for it -- the increased prescriptions.

A. Okay. One of --

MS. FUJIMOTO: Object. Form.

THE WITNESS: So your -- I would say that definitely, there was an increase in prescription -- prescriptions written, which therefore would increase the amount of opioids being used; that is a correct statement. Whether that increase is directly responsible for the entirety of this epidemic, as you call it, there is many other factors leading to this besides just prescriptions.

BY MR. BILEK:

Q. The issue that I'm just asking, is it -- is it one of the factors that is in part the cause?

MS. FUJIMOTO: Object to form.

THE WITNESS: Increased prescriptions will definitely increase the amount of opioids around, definitely. And there is -- you know, nobody is arguing that there was an increase in prescriptions

written. There are many reasons for that, and looking in hindsight, we can say that was probably not the wisest thing.

And again, I lecture and I talk about how we can do safer prescribing and decrease the amount of opioids written. But we also need to get insurance companies to cover alternative treatments that don't rely on opioids.

BY MR. BILEK:

Q. With respect to women, is there anything that, as far as unique issues, in your opinion, for women being prescribed opioids, in that they may react differently --

MS. FUJIMOTO: Object. Form.

BY MR. BILEK:

Q. -- than to men?

A. So for women being prescribed opioids, there are several issues. Women -- as several articles have pointed out, women are prescribed opioids more often for causes, and women also have a less tolerance for opioids. Does that mean that women should never be prescribed opioids? No.

And this is one of the things I talk about a lot, is safe prescribing of opioids for women. And, you know, during pregnancy, there's very few other

options that could be used for pain for women, because the other alternatives are less safe.

We always do a risk/benefit analysis whenever we prescribe any medication during pregnancy. And so, you know, the risk of undertreated pain is -- is possibly worse than the risk of the pain medication.

So, yes, there's always considerations for women being prescribed medications.

Q. Well, you would agree for whatever reason, women seem to have -- to become more likely to become addicted to opioids than men; is that correct?

MS. FUJIMOTO: Object. Form.

THE WITNESS: Women tend to become more -- they have a telescoping effect, so that any substance that is used by women and misused has a greater propensity to cause a use disorder. So even alcohol, if women use alcohol, they are more likely to develop a use disorder earlier in the course of their treatment.

So it's not just with opioids. And I don't think there's any -- we know that women, you know, at smaller doses, because they have smaller body mass, tolerate less. And so it's not that it's specifically more addicting, it's women in general, if they are to become addicted, become addicted sooner to any substance, not just opioids.

BY MR. BILEK:

Q. The -- so the point is, you'd agree that there are special issues in prescribing women opioids, correct?

MS. FUJIMOTO: Object to form.

THE WITNESS: Again, there are special issues about prescribing any medications to women. It's not specific to opioids. And, you know, a lot of studies haven't been done on women because of the risk of -- that they may become pregnant. So we don't know a lot of the differential effects of a lot of medications in women and in women during pregnancy, because they haven't been studied before in that particular case.

So, say, blood pressure medications, we don't know that they work differently for women. There is some evidence that opioids maybe need to be prescribed differently; there's some evidence that it doesn't.

So to say that there are special issues is not entirely correct.

BY MR. BILEK:

Q. Would you agree that there needs to be more studies on prescribing women opioids while they are pregnant?

A. I don't think --

MS. FUJIMOTO: Object. Form.

limited period of time, and trying to reduce the dose or anything like that; is there any type of guideline that you follow in your practice?

MS. FUJIMOTO: Object. Form.

THE WITNESS: Again, if it's, you know, an acute -- treating an acute pain condition, there is the CDC guidelines for the treatment of acute pain and acute postoperative pain. And, yeah, I've actually given lectures on guidelines to treat postoperative pain and post C-section pain, looking at the amount of requirements while the woman is in the hospital and tailoring it to that.

So there's no -- I mean, it's very woman-centered and what she is requiring. So some women need no medications and some women need more.

So, yes, there are guidelines, and those are the ones that I follow.

BY MR. BILEK:

Q. What about for chronic pain, what's your procedure for prescribing opioids for chronic pain?

MS. FUJIMOTO: Object. Form.

THE WITNESS: So the -- I -- the chronic pain that I treat are the ones that I inherit when they become pregnant. I don't start anybody on opioids for chronic pain. Generally, I will keep them on what they

Also encourage breast feeding and other rooming in and advocating for themselves to help prevent NAS.

Q. Why do you -- why do you explain the risks of having NAS to women that are being prescribed opioid prescriptions?

A. Well, NAS is a risk --

MS. FUJIMOTO: Objection. Form.

THE WITNESS: NAS is a risk of a woman taking opioids during pregnancy. You know, approximately 50 to 60 percent of babies will have some degree of NAS. Not all of them will require treatment. And so women need to know this risk so that they can be prepared, and also be able to advocate for themselves so that they can be allowed to room in, so they can get prepared to breast feed, which helps reduce the risk.

I talk to them about smoking cessation, which reduces the risk of having a baby with NAS. And a lot of women already know these risks and are very afraid of these risks. And so sometimes, it's really a matter of debunking some of their -- not debunking, but allaying some of their fears, and really educating them about what the treatment looks like and what they can expect.

BY MR. BILEK:

Q. When you talk about the "treatment," are you

BY MR. BILEK:

Q. Dr. Wright, do you agree that the physicians and the users are the ones that are the cause of the opioid epidemic in California?

MS. FUJIMOTO: Object to form and foundation.

THE WITNESS: Again, I don't think there's any one person that is responsible for the opioid epidemic. I think there's many causes. I would say this article looks bad on the surface, but I don't know the story behind it, and I know that quotes can be taken out of context, having been misquoted many times.

So until I know the whole story behind it, I'm not going to form an opinion one way or the other.

BY MR. BILEK:

Q. Well, let's just say that -- let's put the article aside. Let's say McKesson in the litigation is taking the position that the users and physicians are the ones responsible for the opioid epidemic.

Would you agree that that is a fair statement?

A. I would not.

MS. FUJIMOTO: Objection to form.

THE WITNESS: Again, I'm not familiar with the background behind this. I would not agree that the users are responsible entirely for their -- the epidemic. And I would not agree that the physicians

are responsible entirely for the epidemic. I think there are many causes, going back, you know, 20 years or more, including, you know, the hospital systems and everything else.

To say that, you know, McKesson would be directly responsible for syringes on the street, I can see why they would say that. But again, this kind of article does blame the victims to some extent. But again, I don't know the story behind it.

BY MR. BILEK:

Q. But certainly, as you as being involved in addiction medicine, you would not lay the primary blame on physicians and the users of the opioid epidemic, would you?

MS. FUJIMOTO: Object. Form. Asked and answered.

THE WITNESS: Again, I -- agreed. I told you that -- I answered that question already, that I do not believe that users and physicians are completely responsible for the epidemic. And I wouldn't call them users because that's very stigmatizing language.

People who use drugs are -- they are victims, not causes.

BY MR. BILEK:

Q. Well, McKesson -- have you done any

Q. Well, one of the issues on prescriptions now is that they made a law that you have to show an ID to get a opioid prescription, right, in California?

MS. FUJIMOTO: Object to form.

THE WITNESS: That's been the issue -- I mean, that's been the reality since I've been practicing medicine, so I don't know --

BY MR. BILEK:

Q. This issue of trying to control the number of prescriptions being written, you would agree that the states have been trying to prevent the number or lower the number of prescriptions for opioids; would you agree with that?

A. I have seen -- or I have heard of having limits in certain areas of the amount of opioids given to pharmacists from the states, and I have seen actually that causing harm to patients.

As far as requiring an identification to pick up an opioid, that is to prevent the wrong person from picking up the opioid and, you know, diverting it to another use.

Q. Well, diversion of opioid prescriptions is a huge problem, right?

MS. FUJIMOTO: Object to form.

THE WITNESS: Again, there are -- there are

issues with diversion in many, many areas. So, yes, that can be a large problem if opioids are -- if there's an excess of opioids prescribed, that they can be sold or given to others without a prescription.

BY MR. BILEK:

Q. Now, just -- before you took this case as an expert, did you do any investigation at all of McKesson's role in this opioid epidemic?

MS. FUJIMOTO: Object to form. Asked and answered.

THE WITNESS: When I took this case, I looked into the role of a drug distributor. But again, I'm not a lawyer, so I'm not sure, you know, exactly what the allegations and whether they have merit. I looked -- I know -- you know, somewhat familiar with the distribution system just from the physician's point of view, and so I am looking at it from a physician's point of view and not from a lawyer's point of view.

BY MR. BILEK:

Q. Well, I'm asking you from a physician's point of view. Did you look into it, at the physician's point of view, any of the distributors' role in the opioid epidemic?

MS. FUJIMOTO: Object to form. Asked and answered.

by certain manufacturers that -- again, not -- sorry, I lost my train of thought.

The role of the opioid manufacturers, yeah, just from reading some lay articles on -- you know, some of the manufacturers' marketing to physicians and using, you know, the (inaudible) half-page article and things like that to justify prescribing medications; whereas, you know, before pain was probably undertreated, we've now gone to overtreating pain, and so -- or not treating pain appropriately, I should say, by using multimodal pain relief and other options.

MS. FUJIMOTO: And, Tom, whenever -- whenever a break time is good, subject matter-wise, let's do that, because we've been going probably almost an hour and a half.

BY MR. BILEK:

Q. Okay. So marketing activities to doctors by opioid manufacturers, have you seen any of -- have you personally been marketed to by any opioid manufacturers?

A. I have not. I've heard the stories, but I have not. I work for academia, and even before then, when I was in private practice, I did not have any interaction with opioid manufacturers.

Q. The -- did you -- have you ever been taken to

lunch or had any other payment from a pharmaceutical company other than the expert payments in this case?

A. Well, because I've been practicing for 20 years, back when I was in private practice, there was -- before there was rules against it, we definitely had lunches provided by different, you know, drug companies, usually providing education and pens and other trinkets. I have not since that became outlawed, and especially since becoming an academic physician.

Q. Do you have any understanding of why that practice isn't going on anymore?

MS. FUJIMOTO: Object. Form. Outside scope.

THE WITNESS: My understanding is that any time there could be a conflict of interest, and that when -- even something as small as a pen can influence prescribing behavior.

MR. BILEK: We can take a break right now.

Take about five, ten minutes?

THE WITNESS: Great. Thank you.

MS. FUJIMOTO: Sounds good.

(Break taken.)

BY MR. BILEK:

Q. The issue of long-term health effects on children born with NAS, if the studies showed that there are 24 saying that there is an association of

scientific conclusion?

MS. FUJIMOTO: Object to form.

THE WITNESS: Again, it was, you know, a limited conclusion as far as that particular population in that particular area, yes.

I drew that conclusion based on that data.

BY MR. BILEK:

Q. Now, in your methamphetamine studies, you tried to look at this issue of trying to figure out the confounders, as we have discussed, correct?

A. I did my best to try and control for some of those confounders, correct.

Q. What did you do to control for those confounders?

A. I had a control group that was from the same clinic population, and so I tried to control for just the exposure to methamphetamines. Again found it hard, because, as mentioned in the paper, the limitations did not control for birth weight or weight gain during pregnancy, so could not control for maternal nutrition. And, you know, did the best I could with the information that I had, but cannot control for every confounder.

You know, human studies are extremely difficult. So it's hard to draw conclusions from one

human study; that's why we look at the preponderance of data over many, many studies.

Q. Many, many studies. Also, as you said, on how the studies are run and what they are trying to control for, correct?

A. Correct. We're trying to -- yes.

Q. And, now, with the studies on -- long-term studies on NAS children, have you done an analysis of those studies to see how many people were in the studies and what they controlled for?

MS. FUJIMOTO: Object to form.

THE WITNESS: I've read review articles that have looked at this and looked at the various things, and every time I look at a study, I look at the data and I look at the confounding -- I look for what they look for, I look for their statistical significance, and I read through their limitations.

BY MR. BILEK:

Q. So are you saying that there is no -- that as to your opinion, there is no evidence of long-term problems of children being born with NAS, or is this something that you don't agree with the evidence in which studies have found that there are long-term problems from children born with NAS?

MS. FUJIMOTO: Object. Form.

THE WITNESS: The studies that I've looked at, that I have controlled for as many factors as I can and actually have a good analysis have shown no long-term effects. Some of the studies that have shown long-term effects are earlier studies and poorly designed studies. So the preponderance -- I don't look at just one study. The preponderance of the evidence shows that there are no long-term effects from opioid exposure.

BY MR. BILEK:

Q. So in your opinion, the studies that are out there, you are saying that the more recent studies are the ones that show that there are no long-term effects?

A. No, I just said that some of the studies that showed that there were long-term effects were some of the earlier studies. Some of the more recent studies and some of the studies that did a good job of controlling for the confounders showed no long-term effects.

Q. Okay. What studies are you relying on that say that there are no long-term effects?

A. The studies noted in my report.

Q. Let's turn to your report. And if you could just tell me which studies you are relying on.

MS. FUJIMOTO: Tom, that's Exhibit 2, right?

THE WITNESS: Yeah, I'm looking through -- off the top of my head, I'm trying to remember. I know the Ecker study talks a lot about the long-term effects, and the -- the meta-analysis talks about the different studies throughout that.

BY MR. BILEK:

Q. Okay. So we got the Ecker study that is "Substance Use Disorders in Pregnancy: Clinical, Ethical, and Research Comparatives of the Opioid Epidemic."

A. That's one of them, and the Merhar study.

Q. I'm sorry, I didn't understand you.

A. The Merhar, "Retrospective" --

Q. So we're talking about Merhar study, "Retrospective Review of Neurodevelopmental Outcomes in Infants Treated for Neonatal Abstinence Syndrome"?

A. I believe so, yeah.

Like I said, it's a synthesis of all the information and all of the studies that I've read over the last 15 years in regards to neonatal withdrawal.

So it's these studies, and then the other studies that I've -- Baldacchino, Alex, "Neurobehavioral" --

Q. I'm sorry, I'm not understanding you.

A. The Baldacchino study.

Q. What?
A. Baldacchino study. B-A-L-D-A-C -- Baldacchino.
Q. Baldacchino, "Neurobehavioral Consequences of Chronic Intrauterine Opioid Exposures in Infants and Preschool Children: A Systematic Review and Meta-Analysis."
Is that the one you are referring to?
A. Yeah.
Q. Okay. So we identified three that you are relying on. Any others?
A. I'm sure there's more. I'm just -- without having to go into the articles, it's been a while since I've written this report, so not sure exactly which ones support that, without going into the articles themselves.
Q. Well, you understand this is an important point in this litigation, right?
A. Yes, I understand that's an important point in this litigation, and what I'm saying is, there's no one article that I point to -- there's no smoking gun when it comes to any literature. It's always a synthesis of all of the different literature out there.
Q. Uh-huh.
So -- now, have you looked at the -- the -- the study that was -- the meta-analysis that was done in

sounds familiar.

Q. Okay. Well, let's -- if you'll pull up Exhibit 19, please.

MR. BILEK: Court Reporter, if you could hand her Exhibit 19.

MS. FUJIMOTO: Okay. I've got it, Tom, too.

(Plaintiffs' Exhibit No. 19 Marked for Identification.)

BY MR. BILEK:

Q. Have you reviewed this study?

A. This is not one of the ones that I've reviewed lately. I might have seen it last year.

You said 2019? Yeah.

Q. Is this report something that you would like to review in connection with trying to determine whether there's no evidence of long-term problems?

MS. FUJIMOTO: (Inaudible).

THE WITNESS: This is something I would take into consideration.

Sorry. What did you say?

THE REPORTER: I didn't get the objection.

MS. FUJIMOTO: Object to form.

BY MR. BILEK:

Q. So one of the issues -- well, do you find meta-analysis persuasive in trying to figure out

whether things are caused?

MS. FUJIMOTO: Object to form.

THE WITNESS: I review meta-analysis just as I would any other piece of the medical literature. I would look at the strengths and weaknesses. I would need to know if it was following the guidelines for doing a meta-analysis. And it has to do also with the -- which it looks like this one does -- it also has to do with the underlying studies and the quality of those studies. A meta-analysis of poorly designed studies doesn't give you any more information.

So the whole point of a meta-analysis is to take something with small amounts of studies and pool them together. But if the studies themselves are poorly designed, it's impossible to make any sort of conclusion with a meta-analysis.

BY MR. BILEK:

Q. Do you recall ever making any type of critical analysis of this study, on trying to find out whether this is evidence or not evidence of long-term health problems resulting from a child born with NAS?

A. I have not looked at this particular article other than probably just glancing through it.

Q. Now, one of the things that I would like to ask you about is in this study on "Introduction," so if

of women were using opioids during pregnancy is a stretch.

Q. Okay. How about 20 percent of Medicaid-eligible women, do you think there's some science to that?

A. There was one --

MS. FUJIMOTO: Object to form.

THE WITNESS: There was one study that showed that 20 percent of Medicaid women did receive an opioid prescription. Did not say whether they took that opioid prescription. Did not say that they even filled that opioid prescription they were given. And it didn't say the indications for the opioid prescription.

So it's hard to draw any conclusions from one study.

BY MR. BILEK:

Q. But wasn't that Medicaid study based upon Medicaid payments, Doctor?

MS. FUJIMOTO: Object to form.

THE WITNESS: Again, sorry, it might have been. I'm only looking at the title of the study.

It might have been.

BY MR. BILEK:

Q. Right. So this issue -- the prescriptions were certainly -- the drug companies were receiving the

written in this -- in this report. My report is on the -- the necessary treatment of both chronic pain and addiction and -- with opioids during pregnancy, and the lack of literature supporting long-term effects of opioid use.

BY MR. BILEK:

Q. Well, is it fair to say that you have no opinion?

A. I have lots of opinions, but, you know, again, this is a hypothetical opinion, and that's not what this -- in my understanding, what the purpose of this proceeding is for.

Q. Well, I'm sorry, Doctor, but as your lawyer will tell you, you get to answer questions and I get to ask them. And you can either say "I don't have an opinion," "I have an opinion," or -- and if you do have an opinion, I'm entitled to know what it is.

MS. FUJIMOTO: She answered your question, Counsel.

Do you have another one?

MR. BILEK: No, she did not. She said, I am not going to answer the question, and I'm asking, do you have an opinion?

THE WITNESS: I said it's a hypothetical question, and I answered the question.

other sorts of risks like that.

One -- there is a risk of any medication -- you know, there's -- a lot of medications can be misused. A lot of medications can lead to substance dependence, and by that I mean physical dependence. And then there is the risk of developing a substance use disorder. But that again is a risk of a medication, and then you have to weigh it against the benefits of that medication and any alternatives that exist.

Q. Generally, though, I mean, you would agree one of the risks of an opioid prescription is addiction, right?

MS. FUJIMOTO: Object. Form.

THE WITNESS: In certain populations, they can develop an opioid use disorder if the medication is taken.

BY MR. BILEK:

Q. One of the risks of an opioid prescription is overdose?

A. Again, if it is outside the therapeutic window, it can cause respiratory depression and overdose if -- if the patient takes too much.

Q. And one of the risks is an NAS child?

MS. FUJIMOTO: Object. Form.

THE WITNESS: One of the risks of taking

opioids during pregnancy is having a baby with NAS, correct.

BY MR. BILEK:

Q. Now, Fentanyl, do you think that prescriptions for Fentanyl should be given to women that are pregnant?

MS. FUJIMOTO: Object. Form.

THE WITNESS: Well, we don't give prescriptions for Fentanyl. It's not something that's prescribed outside of the hospital. We give it to pregnant women when they are in labor to treat labor pains, and I think that is a very appropriate order given in the hospital for the treatment of acute pain.

BY MR. BILEK:

Q. Well, what about this issue of -- have you seen any evidence in your addiction practice of Fentanyl prescriptions being abused?

MS. FUJIMOTO: Object. Form.

THE WITNESS: No, I have not seen Fentanyl prescriptions being abused. I have seen street -- patients using Fentanyl-contaminated heroin products that they did not know were existing or have actually sought out Fentanyl illicitly that is imported from China. But I have not seen abuse of Fentanyl prescriptions.

one, right, and there's no others?

MS. FUJIMOTO: Object to form.

THE WITNESS: I'm not -- I'm not a specialist in the treatment of pain, but I do treat pregnant women with pain. And I know that there are very few other alternative medications that can be used during pregnancy that are more safe than opioids.

Again, it's a risk/benefit, and we look at the risk of neonatal abstinence versus the risk of uncontrolled pain. And the other medications that are generally used to treat chronic pain can cause neonatal abstinence also.

BY MR. BILEK:

Q. What other medications are you referring to that cause NAS besides -- that are prescribed to pregnant women?

A. So Gabapentin for one can worsen the effects of NAS, and that is often used. Duloxetine is often used for chronic pain, and it is an SNRI, and also can worsen NAS symptoms. Lyrica or pregabalin is another medication used for chronic pain. Nonsteroidal anti-inflammatories are contraindicated in pregnancy. They can cause premature closure of the ductus arteriosus and can cause hemorrhage during pregnancy, so you can't use it in the first and third trimester.

Q. Now, the -- the issue of -- do you think that the treatment for long-term chronic pain during pregnancy, that using opioids should be discouraged?

MS. FUJIMOTO: Object to form.

THE WITNESS: Again, I don't -- I don't start women on opioids for chronic pain. I continue them on it when it's been started before. We can argue that -- you know, whether or not opioids for the treatment of chronic pain is appropriate or not. I am inheriting women who have been on them, and it's sometimes the safest way -- reason to keep them on it.

BY MR. BILEK:

Q. Would you agree that you are not an expert on treatment for long-term pain of women?

MS. FUJIMOTO: Object.

THE WITNESS: I would agree that I am not a pain specialist, but I do treat chronic pain in women. And I treat chronic pain in women who have developed substance use disorders, and I've treated chronic pain in pregnant women. And so I have seen the medications that are used to treat chronic pain, and I have seen -- and I have continued women on those medications, and I have also switched women from other opioids on to buprenorphine for the treatment of chronic pain.

MR. BILEK: Let's go to Exhibit 9, please.

reviewing and treating -- for treating physicians in your field?

MS. FUJIMOTO: Object. Form.

THE WITNESS: It is something that I would definitely look at. I just joined pain the control committee at my hospital, so it's something definitely that I would look into as I am developing those guidelines.

The Department of Defense and the VA is a very different situation than the one I work in, however, so they would need to be adapted.

BY MR. BILEK:

Q. So going to -- going to page 930.

A. 930? Okay.

Q. It says, "A, we recommend against initiation of long-term opioid therapy for chronic pain. Strongly against."

Do you disagree with the statement by the Department of Defense on that you should be -- that they are probably against it?

MS. FUJIMOTO: Object to form and scope.

THE WITNESS: Again, I do not initiate opioids for the treatment of chronic pain. I only take care of women who have previously been on opioids for the treatment of chronic pain.

So this is not in the scope of my practice.
BY MR. BILEK:
Q. Let's go to maybe something that is strong.
Okay. So would it be fair to state, as far as initiation of long-term opioid therapy, that is not something that you are involved in; your position is continuing while they are pregnant?
A. If it is indicated and they are not wanting or able to taper off, then that is the -- my role is to continue medications that they have already been on or switching them to buprenorphine as a safer alternative.
Q. So -- so going to page 934, where you are, a continuation, if you look up "Dose, Follow-Up, and Taper of Opioids," could you read, "If prescribing opioids," and then "Note," read both of those.
A. "Dose, Follow-Up, and Taper," okay. "Recommendation 10: If prescribing opioids, we recommend prescribing the lowest dose of opioids as indicated by patient-specific risks and benefits. Strong for."
Q. And that "Note: There's no absolutely safe dose of opioids."
Do you as a clinician agree with these statements?
A. I think I already --

MS. FUJIMOTO: Object to form.

THE WITNESS: I think I already said that our -- one of our tenets of all areas of medicine is to prescribe the lowest dose that's effective for the condition needed and for the shortest amount of time.

BY MR. BILEK:

Q. And then what about that there's no absolute low dose of opioids, do you agree or disagree with that?

A. Well, I think there can be. I think it depends on the patient situation and concurring use of other medications and other drugs. So there have been adverse effects with any drug at low dose, so I think -- I can't disagree with there is absolute -- there is no absolute safety in walking outside.

Q. Well, if there is no safe dose for opioids, isn't that a situation that -- do you think there's a safe dose for a fetus for -- during pregnancy of opioid exposure?

MS. FUJIMOTO: Object to form. Foundation.

THE WITNESS: Again, as we talked about, any time we give any kind of medication during pregnancy, it's a risk and a benefit. And as I just stated, there's a risk to everything, including walking outside you can get hit by a car. Does that mean you don't go

children. So just looking at them specifically and calling them NAS kids serves to completely stigmatize them and could cause long-term effects that are worse than the effects of the -- theoretical effects of the drugs themselves.

Q. Now, what about like school lunches, right? We provide school lunches for kids.

We should not provide food for children?

MS. FUJIMOTO: Object to form. Foundation. Relevance.

THE WITNESS: Yeah, again, I'm not seeing the relevance to this. I think -- I think we should provide school lunches to any child that needs school lunches. And I think we should provide developmentally appropriate pediatric care to any child that needs it.

I'm saying we're not supposed to -- we're not supposed to.

We're not -- it does not behoove us to separate one group of children out just because of an exposure when they may or may not need those services. I think all children need a developmentally appropriate child care, and I think all children deserve to be fed.

BY MR. BILEK:

Q. What about health care, don't you think all children deserve to have health care?

that is a Medicaid payment that is to poor children. Isn't it true that poor people are getting stigmatized by a lot of different things?

MS. FUJIMOTO: Object to form. Foundation.

THE WITNESS: I think there -- I think you are confounding -- I think all children getting healthcare does not have anything to do with singling out a specific group and labeling them as children deserving of special care. I think providing child care -- providing healthcare to all children, to provide food to all children regardless of their ability to pay or not, yes, children can get stigmatized -- people can get stigmatized when they go to the grocery store and have to use their SNAP benefits.

That's why they have gone to using more of a debit card as opposed to -- that doesn't look any different, as opposed to, you know, food stamps, which is what they had when I was growing up.

So there is a way that care can be provided in a nonstigmatizing manner.

BY MR. BILEK:

Q. Well, don't you think that there could be lifelines, that health care could be provided to these children that are born with NAS in a nonstigmatizing manner?

for women's rights to take drugs during pregnancy; that's what you advocate for?

A. I advocate --

MS. FUJIMOTO: Objection. Foundation. Scope. Go ahead.

THE WITNESS: I advocate for the compassionate care of women who have a medical condition who -- of addiction who take drugs during pregnancy and have possible complications resulting from that.

BY MR. BILEK:

Q. And you think that women should be given -- that they have the right to take opioid prescriptions regardless of what the harm is to the fetus, right?

A. I have -- I have the opinion that women should be treated appropriately for either chronic acute pain with opioids during pregnancy, if that is deemed the right thing and the appropriate medical treatment. And also, women should be treated appropriately with medication for the treatment of opioid use disorder during pregnancy, as it leads to better outcomes for both the mother and the infant.

Q. But you advocate on behalf of a woman's rights to take opioids during pregnancy, right?

MS. FUJIMOTO: Object to form.

THE WITNESS: I advocate for the appropriate

like the crack cocaine babies in the '80s, we are victimizing them. We are separating them. We are stigmatizing them. So if we are calling them victims, we are then also calling their mothers the -- harmful, which is against the whole idea of motherhood and is anathema to motherhood. So we can't have babies being victims without having mothers being a perpetrator is the point of that statement.

(Discussion off the record.)

BY MR. BILEK:

Q. Do you have any opinion in this case of whether the guardians are bringing any claims to this lawsuit that -- in which they are arguing that the birth mothers are perpetrators of anything, done anything wrong?

A. I'm not familiar with that.

Q. What is the relief you think -- what is your understanding of what the relief that's being sought in this litigation?

A. I don't have an understanding of the complexities of this lawsuit. I was asked to render an opinion on the causes and -- of NAS.

Q. The causes -- you were offering an opinion on the causes of NAS; is that what your scope is?

A. Well, the scope is what is said in my report.

I don't have any opinion about the relief that is -- my understanding of the relief that is being set.

Q. What was the understanding of why you are offering this opinion?

A. Well, my understanding --

MS. FUJIMOTO: Object to form.

THE WITNESS: -- of what I was offering is the understanding of the idea of a class suit, and saying that all women that use opioids are a single class.

BY MR. BILEK:

Q. Well, that's your understanding of what the suit is?

A. That's my understanding of what the suit is.

Q. Let's talk about your maternal consultation during pregnancy. I know we touched on this type of thing before, but I want to be more specific.

What types of behavior do you advise pregnant women to avoid?

MS. FUJIMOTO: Object to form.

THE WITNESS: I advise pregnant women to avoid things that would cause them harm during pregnancy, such as horseback riding, scuba diving. You know, things that could cause them to be injured.

BY MR. BILEK:

Q. Okay. Do you discourage them from the use of

lives?

MS. FUJIMOTO: Object to form.

THE WITNESS: That's -- I'm not going without -- sorry.

That is one thing, that sometimes it is lifelong treatment, and sometimes women need just temporary treatment. What I usually counsel women is to stay on their opioid replacement for at least a year postpartum. And sometimes it is lifelong, and women do much better.

We know with opioid use disorders that have been on methadone, there are some people that are on methadone for long periods of time, and they do much better when they are on it, just like people need to be on insulin for the rest of their lives.

BY MR. BILEK:

Q. So what you are saying, just to be clear, is that for these women that are addicted to opioids -- the rest of their lives?

A. We lost you.

MS. FUJIMOTO: Object to form.

THE WITNESS: We lost you.

Could you restate that question, please?

BY MR. BILEK:

Q. Yes, I can.